I put her on the bromide of quinin gr. 5 three times a day in pill form.

Specimen Presented. Mrs. Stevenson. 54 years of age. Widow. Two daughters. Husband died when she had been married only 4 years and she has worked very hard all her life to support herself and children. Some years ago she was told in Iowa that she had a fibroid of the uterus. A similar diagnosis was made in San Francisco.

On the 28th of August, while lifting a mattress, she felt a pain in her right iliac region. She had occasional spells during the day, and at three o'clock in the morning of the 29th was taken with a very severe pain and vomiting which continued. I saw her in the afternoon. There was marked tenderness in the lower abdomen, a palpable tumor exquisitely tender; still nauseated; no bowel movement; no temperature. She was removed to St. Mary's Hospital with a provisional diagnosis of a fibroid with a twisted pedicle.

Aug. 30th, operation: Before the peritoneum was opened, a dark mass was seen which on palpation fluctuated and the diagnosis was changed to strangulated ovarian cyst. There was some dark, free blood in the peritoneum; the cyst was lifted out entire; an intra-mural fibroid was found in the uterus, and as on palpation a polyp had been felt projecting from the cervix, a complete hysterectomy was performed.

Patient was up on the 10th day and left the hospital on the 14th day.

On splitting the uterus its cavity was found to be filled by a polyp whose pedicle was attached to the fundus.

Mr. G. U. Patrick. Was seen by me in consultation with Dr. R. J. Nicholls on July 29, 1911. Patient is 38 years of age; a miner; married; no children. His father was killed in a mine at the age of 42. His mother died at the age of 22 in confinement. No brothers or sisters. The only sickness he remembers before the present trouble was ptomaine poisoning from shrimp salad in January, 1910. He was very sick for one night and had bowel disturbance until July, 1910.

His present trouble started in December, 1910. He never had a diarrhea, never had dysentery or typhoid fever. Severe pains and constipation began in March, 1911. He complained that riding in a buggy or a car brought on attacks of pain in the right side. These lasted for an hour or two and then disappeared under massage. These attacks occasionally occurred without any exciting cause. He found that when these attacks were on a lump formed in the right iliac region, which disappeared on rubbing.

On examination this phenomenon was observed; a mass forming in the right iliac region, but also in the right hypochondriac following usually the disappearance of the former. He was sent to the German Hospital, the lower bowel inflated, and it was found that the abdominal cavity below and to the left of a line drawn from the tip of the left 8th rib to the right anterior superior spine of the ilium, became inflated and produced pain. From that we concluded that the transverse colon was attached somewhere in the right iliac region. Gastric analysis gave the results usually accompanying carcinoma of the stomach with the exception of the absence of blood. A series of X-ray pictures, taken after the ingestion of bismuth gruel, showed that there was an obstruction on the right side, where the bismuth was partly retained.

August 3d, operation: An incision was made in the outer border of the right rectus muscle; a small, hard mass was palpated, not very movable owing to adhesions passing across the transverse colon. These were liberated and the proximal end of the colon was so distended and thickened as to resemble the stomach. The appendix was very long and distended with fecal matter, evidently due to backward pressure. The mass in the transverse colon was resected; the two ends brought together with large Murphy button.

The lymphnodes attached to the mass were sent to Prof. Ophuls, who reported no tumor; diagnosis—catarrhal lymph-adenitis. The piece of bowel was then submitted for examination and the report came carcinomatous ulcer of the colon.

Patient developed an ether pneumonia but responded promptly to a few hypodermics of digalen.

On the 9th day patient was up.

On the 11th day a Roentgen picture revealed the Murphy button still in situ, and the patient left the hospital.

On the 14th day patient came to the office complaining that his hemorrhoids bothered him. He was given some ointment and told to use cold applications. He returned the following day with the statement that there was an obstruction in the lower rectum. It proved to be the Murphy button, which required removal by forceps.

A letter from Dutch Flat, dated September 2nd, states that the patient is feeling splendidly, has gained 7 pounds, but still takes a little cascara every night for his bowels.

Surgical Section, Sept. 19, 1911.

By JNO. C. NEWTON, M. D., San Francisco.

This is a case of external anthrax. We know that the anthrax bacillus is of special historical interest on account of its being the first micro organism proved definitely to have a specific etiological relationship to an infectious disease. More animals (cattle and sheep) succumb to anthrax than of any of the other diseases affecting them.

This patient came in from the country this afternoon, complaining of swelling and stiffness of his hand and arm and the three pustules seen on his thumb and finger.

The history begins three days ago. The patient is a milker and gives the information that he had assisted in the burying of several cows that had died from some unknown cause. There were slight abrasions on his hand and from these places the condition seen here rapidly developed. His temperature is 101, pulse 112. The carbuncular lesions are capped with characteristic bluish vesicles.

The anthrax bacilli has been demonstrated in smears made from the Sero Sanguineous contents of the vesicles. In the case I previously presented to the society in Sept., '09, which is reported in the State Journal of Jan., 1910, the diagnosis was verified by guinea pig inoculation. I will treat this condition by injecting 0.35 of pure carbolic acid into each pustule and follow this by mild germicidal applications. He is receiving 0.35 each of guaiacol and quinin sulphate internally.

A vaccine will be used if the condition does not yield to this treatment. The prognosis is bad in all forms (Ravenel) and the mortality of external anthrax is variously given at from 5 to 25%. The pulmonary form (wool sorters' disease) is largely fatal.

On the Paralysis of the Abducens of Otitic Origin.*

By VICTOR F. LUCCHETTI, M. D., San Francisco.

At the last meeting of the Eye and Ear Section of the County Medical Society, an interesting case having a symptom complex known as Gradenigo's Syndrome was presented and discussed; and Dr. Welty, chairman of our section, requested me to make an extensive report on the above disease at this meeting. The condition is such a rare and interesting one to the specialist and profession at large from an anatomical and pathological standpoint, that I deemed it advisable to present in full the views of the author regarding this affection.

Prof. Gradenigo does not agree with Citelli that one should speak in a general way of Gradenigo's Syndrome; but rather of a well defined and pathological condition.

* Read before the Eye, Ear, Nose and Throat Section of the San Francisco County Medical Society, Sept. 26th, 1911.